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ABSTRACT

A practice laboratory for writing nursing care plans to be utilized by first-year nursing faculty members was developed. Six first-year instructors of the Long Beach City (California) College Associate Degree Nursing Program were the participating panel of experts. A thorough literature review was conducted to obtain guidelines for writing nursing care plans. Each step in the process of developing the practice laboratory was presented to the experts for review, and materials were revised in accordance with their recommendations. The learning activities were also developed from the content taught in the courses, Homeostasis, Major Health Problems, and Developmental Levels. Recommendations included: the practice laboratory be used in the spring of 1988; the curriculum be evaluated to incorporate practice laboratories for writing nursing care plans in the second-year of the nursing program; provisions be made for validating the use of the practice laboratory after one year; and review of the curriculum be made to determine if the laboratory could become a credit course. The nursing care plan and skills laboratory are appended. Tables are included. The document contains 23 references. (SM)

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DEVELOPMENT OF A PRACTICE LABORATORY FOR THE WRITING OF NURSING CARE PLANS

CURRICULUM AND PROGRAM PLANNING

by

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A Practicum presented to Nova University in partial fulfillment of the requirements for the degree of Doctor of Education

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ABSTRACT

DEVELOPMENT OF A PRACTICE LABORATORY FOR
THE WRITING OF NURSING CARE PLANS

Brenda McCane Harrell, R.N., M.S.N.

The purpose of this investigation was to develop a practice laboratory for the writing of nursing care plans to be utilized by the first-year nursing faculty members. Six first-year instructors of the Long Beach City College Associate Degree Nursing Program were chosen as the panel of experts to participate in the investigation. A thorough review if the literature was conducted to obtain the guidelines for writing nursing care plans. The guidelines for writing nursing care plans include the use of the nursing process as the framewok and patient problems stated in terms of a nursing diagnosis and not a medical diagnosis. Each step in the process of developing the practice laboratory was presented to the panel of experts who were asked to review the materials. The materials were then revised in accordance with the panel's recommendations. The revised materials were then presented to the expert panel for their approval. The process was continued until the materials were approved as presented.

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The content of the practice laboratory was based on the review of the literature and input from the panel of experts. The learning activities were also developed from the content taught in the courses, Homeostasis, Major Health Problems, and Developmental Levels.

Recommendations included that the practice laboratory be utilized in the spring of 1988; that the curriculum be evaluated for the purpose of incoperating practice laboratories for writing nursing care plans in the second-year of the nursing program; that provisions be made for validating the use of the practice laboratory after it has been in effect for one year; that review of the curriculum be made to determine if the laboratory could become a credit course; and, that further study be done on the teaching of nursing care plans.

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Chapter 1

INTRODUCTION

Underlying Problem

The nursing curriculum at Long Beach City College is comprised of ten, six week courses (modules) covering four academic semesters. A maximum of 60 students can be placed in each course. The student teacher ratio in the laboratory portion of the course (module) is 12:1 as requested by the administration of the clinical agencies utilized and recommended by the Board of Registered Nursing accreditation criteria.

First-year nursing students enrolled in the Long Beach City College Associate Degree Nursing Program were taught how to write a nursing care plan in the first semester of the nursing program. The skill was taught by lecture discussion in a classroom setting and students going to the hospital to gather data from the patient, kardex, and chart under teacher supervision. The nursing care plan was designed to follow the nursing process, which, in turn, reflected the philosophy of the nursing curriculum.

Many faculty members at Long Beach City College Associate Degree Nursing Program believe that if the

foundation for developing care plans has been good, students would be more successful in understanding the curriculum and developing better nursing care plans.

Purpose of the Study

The purpose of this study was to develop a practice laboratory for writing nursing care plans. The practice laboratory is a predetermined time for students to meet and perform specified learning activities for writing nursing care plans under the supervision of an instructor.

Method of Investigation

This investigation was carried out by utilizing developmental research as follows: Six first-year faculty members at Long Beach City College participated in the study. Each faculty member was requested to review the modules taught in the first year of the nursing program for the purpose of devising learning activities, related to the content of the module, that could be used in the practice laboratory for writing nursing care plans. Recommended learning activities were devised by the writer of this practicum according to the guidelines for writing nursing care plans and submitted to the panel members for approval.

Chapter 2

BACKGROUND AND SIGNIFICANCE

Background

The nursing care plan serves several useful purposes in the clinical setting. It is an effective method for documenting independent nursing practice and utilization of the nursing process. Nursing care plans can increase continuity of care, conserve time, and facilitate communication among health care givers.

Historically speaking, faculty members of Long Beach City College Associate Degree Nursing Program have expressed concern that students do not write nursing care plans as well as they should. In the first year of the program, students were taught the nursing process to facilitate their being able to write a nursing care plan. This study was conducted in order to devise a practice laboratory for the purpose of writing nursing care plans. Writing nursing care plans is a skill that is introduced to the beginning nursing student; therefore, it is necessary to provide as many learning activities as possible for the student.

Significance to the Institution

Long Beach City College offers a two year associate degree in nursing. It is the expectation of all the health care facilities in the area that registered nurses be able to write nursing care plans as part of their responsibilities in planning and delivering nursing care to patients.

In that the majority of the students graduating from Long Beach City College Associate Degree Nursing Program are employed in the metropolitan area of Long Beach, it is the concern of the faculty that the students are prepared to enter the work force. This study was undertaken to provide another means by which faculty can help nursing students to better prepare themselves for writing nursing care plans.

Relationship to the Seminar

This practicum was appropriate to the Curriculum and Program Planning Seminar because it focused on a goal of learning. The goals of learning are classified as follows: cognitive (intellectual), affective (values, attitudes, feelings) and psycho-motor (motor skills). These goals assisted in the decision making process for the use of different teaching strategies.

Review of Literature

The review of literature focused on the following areas: the nursing process and its components, nursing care plans, and the application of nursing care plans in the clinical setting.

Over the years, nursing has changed its focus from concern, in which actions were based on custom, to providing care that has been designed methodically, is based on sound rationales, and is individualized to meet the needs of each health care consumer. In order to deliver this type of care, the nursing process evolved.

According to Potter and Perry (1985) the nursing process provides the organizational structure and framework for nursing care, yet is creative and flexible enough to be used in various settings. The purposes are to identify the client's health care needs, to establish a nursing care plan to meet those needs, and to complete the nursing interventions designed to meet the needs.

The components of the nursing process-assessment, nursing diagnosis, planning. implementation, and evaluation-provide the organizational structure for achieving the purpose of the process. The basic characteristics of the nursing process as indicated by

Wolff, Weitzel, et al (1983) are: it is problem-oriented, goal-oriented, orderly and planned, step by step, open to accepting additional information during its application, and is universally applicable to all patients, families, and communities that nursing serves.

The first component of the nursing process is assessment. The nursing assessment is the process of gathering, verifying, and communicating data about a client. The purpose of the assessment is to establish a data base about the client's level of wellness, health practicees, past illnesses and related experiences, and health care goals (Potter and Perry, 1985: 139).

According to Wolff, Weitzel, et al (1983: 201), there are five steps in the process of nursing assessment: 1) collecting data concerning the patient's health-illness status, 2) comparing data with standards, 3) analyzing findings when data are compared with standards, 4) stating nursing diagnoses, and 5)ranking nursing diagnoses in order of priority.

The collection of data is often described as the most important step in the nursing process. It is the necessary ingredient for providing nursing care that is individualized and appropriate to help solve the patient's health problem. Potter and Perry (1985:

139) states that data should be descriptive, concise, and complete and should not include interpretative statements.

There are two types of data: objective and subjective. Objective data are observations or measurements by the data collector. It is information perceptible to the senses. Subjective data are the client's perceptions about his health problem; they cannot be perceived by another person.

A data source can be the client, the family, or significant others, health team members, the health records, other records, and pertinent nursing and medical literature. The two most common methods for gathering data used in nursing are interviewing and observation (Wolff, Weitzel, et al: 1983).

After completing the nursing assessment the nurse proceeds to the second component of the nursing process, the nursing diagnosis. A nursing diagnosis is a statement of the potential or actual problem in the client's health status that the nurse is competent to treat. The overall purpose of the nursing diagnosis is to interpret assessment data and thus identify health problems that may involve the client, the family, and significant others (Potter and Perry, 1985: 161).

The Nursing Practice Act considers a nurse competent when he/she consistently demonstrates the

ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process by formulating a nursing diagnosis through observation of the client's physical condition and behavior, and interpreting information obtained from the client and others, including the health team (BRN Report, 1987).

The diagnostic process includes three major elements: analysis and interpretation of data, identification of client problems, and formulation of nursing diagnoses.

Nursing diagnoses have certain characteristics: 1) they state a clear and concise health problem, 2) they are derived from existing evidence about the patient and from sound nursing knowledge, 3) they are potentially amenable to nursing therapy, 4) they are the basis for planning and carrying out nursing care, and 5) they are patient centered (Wolff, Weitzel, et al 1983).

The ability to distinguish between medical and nursing diagnosis is important if the nurse is to identify accurately problems which can be alleviated within the domain of nursing. A nursing diagnosis describes the result of achange in life style or function and is based on nursing observations of patient's behavioral and physiologic responses to stress (Fraher, 1983: 95).

Nursing diagnosis actually defines the practice of nursing. The use of nursing diagnosis defines what and demonstrates convincingly how what nursing does is distinct from what doctors and other health care professionals do (Tartaglia, 1985: 34).

Some nurses believe that the focus of nursing diagnosis on actual or potential problems is too limiting and does not take into account factors such as personal growth or health maintenance. An approach to nursing diagnosis that focuses on only actual or potential problems leads the nurse to look for problems. If no problem exists, the nurse must identify potential problems. Depending on assessment data, identification of potential problems may or may not be possible (Stolte, 1986: 13).

The formulation of nursing diagnoses enables the nurse and client together to determine client goals, priorities, and projected coutcomes of nursing care in the planning component (Perry and Potter, 1985: 169).

The nursing assessment and the formulation of nursing diagnoses initiate the individualization, coordination, and continuity of nursing care that is planned during the third component of the nursing process. Planning is a category of nursing behaviors in which the goals of care set for an individual client and a strategy is designed to achieve goals (Perry and Potter, 1985: 171).

Wolff, Weitzel, Zornow, Zaohar (1983) identified the steps in the process of planning nursing care; 1) writing objectives or goals of nursing care, 2) identifying alternatives of nursing care, 3)selecting nursing measures that are most likely to meet objectives or goals of care, 4) writing nursing orders, and 5) writing the nursing care plan. Planning establishes the framework of nursing care to be delivered during the fourth component of the nursing process, implementation.

Implementation is a category of nursing behavior in which the actions necessary for accomplishing the health care plan are initiated and completed. Implementing includes the nurse's performing or assisting in the performance of the client's activities of daily living, counseling and teaching the client or client's family, giving care to achieve therapeutic goals and to facilitate the achievement of the client's health goals, supervising and evaluating the work of staff members, and recording and exchanging information relevant to the client's continued health care (Potter and Perry, 1985: 189).

The purpose of implementation is to carry out the nursing care plan developed in the previous component of the nursing process. Like other components of the nursing process, implementation is continuous and interacts with the other components. During

implementation the nurse reassesses the client, modifies the plan of care, and rewrites projected outcomes as necessary.

The last component of the nursing process, evaluation, measures the client's response to nursing actions, the client's progress toward achieving the health care goal, the qualtiy of nursing care provided in an institution or agency, and the level of nursing care for an individual client (Potter and Perry 1985: 203).

Positive evaluations can lead the nurse to conclude that the plan was effective and negative evaluations indicate that the problem was not solved and that modifications in the plan are necessary. The evaluation process can identify specific factors resulting in the success or failure of the plan.

The evaluation component of the nursing process is oriented toward the client who is receiving nursing care, as well as toward the institution that is providing care (Potter and Perry, 1985: 202).

The Nursing Practice Act states that nurses must evaluate the effectiveness of the care plan through observation of the client's physical conditiona nd behavior, signs and symptoms of illness, and reactions to treatment, and through communication with the client and health team members, and modifies the plan as needed (BRN Report, 1987).

Nursing Care Plans

The final product of the planning component is the nursing care plan. The nursing care plan is based on the data obtained during assessment and the nursing diagnosis, priorities, and goals developed during analysis. Generally nursing care plans involve the four areas of the nursing care problem, the goals, the specific actions by the nurse, and the projected evaluation of the client's responses to the nursing actions (Potter and Perry, 1985: 173).

The nursing care plan organizes information about the patient into a meaningful whole (Kozier and Erb 1983: 148). The patient's care plan is started as soon as the patient is admitted to the health care agency by the responsible nurse. It is constantly updated and revised throughout the patient's stay, in response to changes in the patient's condition and evaluation of goal achievement.

Many suggestions for forms on which to write the nursing care plan appear in the literature. Each health agency ordinarily has its own form for the nursing care plan. No one form is likely to be best for all patients.

The Nursing Practice Act also indicates that in order for nurses to be considered competent they must formulate a care plan, in collaboration with the

client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene and protection, and for disease prevention and restorational measures (BRN Report, 1987).

The nursing care plan is a written guideline for client care so that specific nursing care can be quickly grasped. It increases communication between nurses and facilitates the continuity of care from one nurse to another and from one health care setting to another. The nursing care plan is a method for teaching students how to transfer knowledge gained from nursing and medical literature and the classroom into practical experience (Potter and Perry, 1985: 187).

Application in the Clinical Setting

The nursing care plan is a guide that may be used to implement the appropriate type of nursing care for any patient. It is utilized in the acute areas of care and well as the none acute areas.

McConnell (1982) identified some of the reasons staff nurses give for not writing nursing care plans as: "takes too long....never up to date anyway....too cluttered." Because the basic problem continues to center on the fact that care plans don't meet a recognized need of staff nurses, they are are always failure-laden (Manthey, 1981).

The negative attitudes that the ambiguity and misuse of care plans have created is a difficult problem to overcome. After the problems with purpose and negative emotions comes the problems of form and design and location (Manthey,1981).

Carlson (1986) surveyed 21 nursing units and reported that nursing care plans were not being written for each patient within 24 hours after admission to the hospital. One of nursing management's first reactions as to why nurses do not write nursing care plans is that there is a training problem (Roeder,1980).

Williams (1984) identified the following advantages of written nursing care plans after her institution had used them for a period of time: reinforces acountability, teaching tools, set priorities, provide continuity, help orient relief nurses, provide documentation, save time, and are more accurate. The biggest complaint is the time taken away fom bedside nursing.

Technological advancements have played a great part in patients being able to receive better medical care. Computerization of patient care is becoming somewhat of a necessity due to the involvement of many medical professionals in a single patient's care. When the process of creating the patient care plan is computerized, nurses are freed to draw more on the full

breadth of their training and expertise (Walters,1986).

The review of the literature was organized to include background data pertinent to the areas that are significant in writing nursing care plans. The areas that were investigated included: 1) the nursing process, 2) nursing care plans, and 3) application of nursing care plans in the clinical setting. All of these areas were seen to influence the writing of nursing care plans.

The literature supports the use of nursing care plans in all areas of nursing. The nursing process is a good basis for writing the care plans. The basic problems with writing and utilizing nursing care plans in the practical setting are negative attitudes, not enough time to write them, inadequate design and location of care plans.

This review of literature did not provide information on how to teach the writing of nursing care plans.

Chapter 3

PROCEDURES

This investigation was undertaken to develop a practice laboratory for the purpose of writing nursing care plans. The following section will describe the procedures utilized in order to carry this investigation out.

Six faculty members who taught in the first year of the Long Beach City College Associate Degree Nursing Program were selected to participate in this study. The following criteria were used in selecting the the panel of experts: (1) each instructor taught on a full-time basis in the program, (2) each instructor had taught in the first year of the program two years or more, and (3) each instructor was responsible for a clinical group.

The instructors that comprise the panel of experts have all had the experience of teaching each of the four modules that were taught in the first year of the program. It was in each of the four modules that the students learned to write the nursing care plan.

A review of the literature in the areas of the nursing process and nursing care plans was made to ascertain the basic guidelines for writing nursing care

plans. These guidelines were listed on a handout and were given to each member of the panel of experts to use as criteria for selection of their learning activities based upon the content taught in the first year of the nursing program.

Each member of the panel of experts was asked to review the content that she was responsible for teaching in each of the modules that were taught in the first year of the nursing program. The purpose of this review was to devise a list of learning activities, based upon the module content, for the practice laboratory.

All members of the panel reviewed the first two modules, Basic Human Needs and Homeostasis, that were taught in the first semester of the program. It was because all the members of the panel were responsible for teaching these modules that they were asked to review them. Three members of the panel reviewed the module, Major Health Problems and three members reviewed the module, Developmental Levels.

Upon completion of the review of the modules, the members of the panel met with the researcher to review the learning activities that had been selected by the researcher, utilizing the guidelines found in the review of literature, for writing nursing care plans.

The panel of experts reviewed the submitted

learning activities with recommendations to delete some of the proposed learning activities.

The revised list of learning activities were again submitted to the panel of experts for review and their input. The revised list of learning exercises were accepted by the panel for implementation.

Definition of Terms

The following terms were used in this practicum:

Module: a course that is six weeks in length with specified objectives and learning activities.

Practice Laboratory: a predetermined time for students to meet and perform specified learning activities for writing nursing care plans under the supervision of an instructor.

Long Beach City College: A California community college that offers open access to low cost, comprehensive, instructional programs in higher education that are responsive to the diverse needs of the community.

Chapter 4

FINDINGS

The review of literature revealed two guidelines for the writing of nursing care plans. The nursing process is the framework for the nursing care plan; including the components of assessment, nursing diagnosis, planning, implementation and evaluation. The process is central to all nursing actions and is the essence of nursing (Doenges, Jeffries, and Moorhouse, 1984).

The second guideline was that patient problems are to be stated in terms of a nursing diagnosis and not as a medical diagnosis. The nursing diagnosis is the crux of the nursing care plan and the prime determinant of the style of nursing care to be administered (Doenges, Jeffries, and Moorhouse, 1984).

The panel of experts suggested that learning activities for the practice laboratory be devised for three of the four modules, Homeostasis, Major Health Problems, and Developmental Levels. The panel of experts decided that it was not necessary to include the Basic Human Needs module, therefore it was deleted from the practice laboratory.

The panel of experts recommended that the already

developed care plan for the first-year nursing student be used in the practice laboratory by the student (Appendix A). Many suggestions for forms on which to write nursing care plans appear in the literature. Each agency is likely to have their own form for writing nursing care plans.

The course description for the practice laboratory was approved by the panel of experts as follows: Designed to develop skill in the planning and implementation of nursing care of the hospitalized adult patient and the newborn. Activities include assessing physical and psychological needs, making nursing diagnoses, and planning nursing care.

It was recommended that the student attend the practice laboratory 3 hours per week. This time would be deducted from the on campus scheduled laboratory time. The panel of experts felt strongly that 2 hours of practice time per week would be enough therefore one hour was deleted from the practice laboratory.

Based on the review of the literature a tentative list of learning activities for the Homeostasis module was prepared and presented to the panel of experts. The members of the panel accepted the list of learning activities as they were presented for the Homeostasis module. The learning activities devised for the Homeostasis module were patient problems/needs related

to immobility and oxygen deprivation. Table 1 shows the learning activities devised for the Homeostasis module.

Table 1

Learning Activities For The Homeostasis Module

Patient Problems/Needs
Oxygen Deprivation
Immobility Disorders

Based on the literature review a tentative list of learning activities for the Major Health Problems module was prepared and presented to the panel of experts for their input and approval. The panel elected to delete any of the patient problems that were similar in nature to a particular biological system. Instead a broad category of similar problems was suggested. It was the general consensus of the panel that this would be much more benificial to the student in terms of applying their nursing care plans in the clinical setting.

After the suggested changes were made, the members of the panel of experts accepted the list of learning activities for the Major Health Problems module. The

learning activities that were devised for the Major Health Problems module were problems related to preoperative and postoperative care, gastrointestinal disorders, cardiac disorders, oncology problems, fluid and electrolyte problems and metabolic disorders (See Table 2).

Table 2

Learning Activities For The Major Health Problems Module

Patient Problems/Needs
Preoperative and Postoperative Care
Gastrointestinal Disorders
Hiatal Hernia
Gastritis
Hemorrhage
Peptic Ulcer
Inflammatory Bowel Disease
Cardiac Problems
Coronary Artery Disease
Congestive Heart Failure
Metabolic Disorders
Diabetes
Onocologic Conditions
Fluid and Electrolyte Imbalance

According to the review of the literature a tentative list of learning activities for the Developmental Levels module was prepared and presented to the panel of experts for their input and approval. Several members of the expert panel suggested that learning activities for the postpartum mother include the stages of care for one hour pastpartum, 48 hours postpartum, and care for the postoperative C-section mother. After consulting with the remaining members of the expert panel a consensus was reached and the three stages, one hour postpartum, 48 hours postpartum, and the C-section mother, were added to the list of learning activities.

After the above changes were made, the members of the expert panel accepted the list of learning activities for the Developmental Levels module.

Two days later, a member of the expert panel suggested that learning activities for brain injury be deleted and instead include learning activities for head trauma. It was the notion that learning activities for head trauma would allow the student a broader base in which to write nursing care plans.

Again, the remaining panel members were consulted and a consensus was reached to delete brain injury and add head trauma to the list of learning activities for the Developmental Levels module. The committee

expressed this to be an important addition to the list of learning activities for the Developmental Levels module.

After the above changes were made, the members of the expert panel accepted the list of content for the Developmental Levels module.

The learning activities that were devised for the Developmental Levels module were patient problems/needs related to chronic conditions with a rehabilitation focus, and prototypes for the newborn and the postpartum patient (See Table 3).

Table 3

Learning Activities For The Developmental Levels Module

Patient Problems/Needs
Chronic Conditions
Cerebralvascular Accident
Head Trauma
Chronic Obstructive Pulmonary Disease
Hip Traumas/Fractures
Prototypes
Newborn/Infant
Postpartum mother - 1 hour, 48 hours, C-section

The practice laboratory for writing nursing care plans was drafted. The practice laboratory contained the course description, time allotment, how skill will be learned, teacher responsibilities, student responsibilities, and the learning activities assignments. The draft of the practice laboratory was given to the members of the expert panel for their input and approval.

The members of the expert panel indicated their approval for the course description as stated earlier in this chapter and as stated in the draft of the practice laboratory (Appendix B). The time allotment of 2 hours for the practice laboratory was also approved for the practice laboratory.

The panel of experts suggested that reviewing all classroom content as necessary be added to the section on how the skill will be learned. Members of the panel indicated adding the statement 'prior to the laboratory, review all care plan materials as necessary' to the section on student responsibilities.

Following the changes made by the panel of experts, the practice laboratory was approved by the panel of experts. The practice laboratory can be found in Appendix B.

Chapter 5

DISCUSSION, IMPLICATIONS, AND RECOMMENDATIONS

Discussion

This investigation was conducted to develop a practice laboratory for writing nursing care plans. The review of literature pointed out that the basic framework for writing nursing care plans is the nursing process. This was a guideline that the panel of experts used to decide upon the learning activities that were to be used for the practice laboratory.

The panel of experts feedback toward the practice laboratory was very positive in that they felt that students would gain an added opportunity to become more skillful in writing nursing care plans. The laboratory would also assist students in refining their assessment skills such that the skill would be performed in a more timely manner.

Nothing was found in the review of literature concerning how to teach the writing of nursing care plans. It is possible that other factors or guidelines should be included when teaching the writing of nursing care plans.

The learning activities that were devised for the practice laboratory are certainly applicable to the nursing process. Nursing diagnosis may be made from the assessments or information gathering pertaining to the specified activities for the practice laboratory also.

It was the general consensus of the panel of experts that a practice laboratory for writing nursing care plans was an important addition in that distractors are removed and allows the student to improve their performance.

The review of literature also pointed out that care plans are an essential aspect of the nurses responsibility in caring for the patient. It is because of the importance of writing nursing care plans in the clinical setting that students should have a strong background in writing nursing care plans.

Implications

This investigation has implications for the nursing faculty at Long Beach City College in that they have expressed concern for helping students increase their performance in writing nursing care plans. The results of this investigation has provided another teaching strategy for the faculty's use in assisting nursing students in writing nursing care plans.

Recommendations

The following recommendations are made based upon the findings of this investigation:

1. The Practice Laboratory be placed in the Major Health Problems module for the spring semester of 1988.

2. Further review of the curriculum be made for the purpose of incorporating more laboratory time for students to practice writing nursing care plans beyond the first year of the nursing program. According to the review of the literature, this is an ongoing skill that needs to be perfected even into the role of registered nurse.

3. Provisions for validating this investigation be made after it has been in effect for one year. This was a developmental investigation and its validity has not been tested.

4. Further review of the curriculum be made to determine if the laboratory could become a credit course.

5. Further study be done in the area of teaching the writing of nursing care plans.

REFERENCES

Carlson, Laura B. "Does Attitude Really Influence the Writing of Nursing Care Plans?," Journal of Nursing Administration, 1986 Jan 16(1). p 42.

Carpenito, Lynda Juall. Handbook of Nursing Diagnosis. Philadelphia: J. B. Lippincott, 1984.

Doenges, Marilynn, Mary F. Jeffries, and Mary F. Moorhouse. Nursing Care Plans: Nursing Diagnoses In Planning Patient Care. Philadelphia: F. A. Davis Company, 1984.

Fraher, Jane E. "Nursing Diagnoses and Care Plans in Critical Care,"Critical Care Nurse, Nov/Dec 1983: 94-97.

Forman, Mary. "Building A Better Nursing Care Plan," American Journal of Nursing, June 1979: 1086-1087.

Fuerst, Elinor, Wolff, L. and Weitzel, M. Fundamentals of Nursing. Philadelphia: J. B. Lippincott, 1974.

Kozier, Barbara and Erb, Glenora. Fundamentals of Nursing: Concepts and Procedures. Menlo Park, Ca.: Addison-Wesley, 1983.

Kershaw, Janet E. "Teaching the Nursing Process: Standard Care Plans,"Nursing Times, August 1979: 1413-1416.

Manthey, Marie. "Nursing Care Plans," Nursing Management, 1981 Sept 33 (9). pp 29-31.

McConnell, Edwina. "How Nursing Care Plans Help You." Nursing Life, 1982 Jan/Feb (2). pp 55-59.

Potter, Patricia and Perry, Anne G. Fundamentals of Nursing: Concepts, Process, and Practice. St. Lousis: C. V. Mosby, 1985.

Pope Sharon S. "The "Problem" of Nursing Care Plans." Supervisor Nurse, January 1977: 25-27.

Prato, Sue Ann. "Nurses Don't Need Care Plans." Supervisor Nurse, 1977 Jan 8 (1). p 32.

Rang, Mary Lu. Manual of Newborn Care Plans. Boston: Little, Brown and Company, 1981.

Roeder, Mary Alice. "Patient Care Plans and the Evaluation of Nursing Process," Supervisor Nurse, June 1980: 57-58.

Smeltzer, Carolyn. "Teaching the Nursing Process-Practical Method." Journal of Nursing Education, 1980 Nov. 19(9). pp 31-37.

Stolte, Karen. "Nursing Diagnosis and The Childbearing Woman." The American Journal of Maternal/Child Nursing, 1986 Jan/Feb: 13-15.

Tartaglia, Michael J. "Nursing Diagnosis: Keystone of Your Care Plan." Nursing 85, 1985 Mar, 15(3). pp 34-37.

Vandenbosch, Terry, Bentley, C., et al. "Tayloring Care Plans to Nursing Diagnosis." American Journal of Nursing, 1986 Mar, 86(3). pp 313-314.

Walters, Shirley. "Computerized Care Plans Help Nurses Achieve Quality Patient Care." Journal of Nursing Administration, 1986 Nov. 16(11). pp. 33-39.

Williams, Shirley. "Rx for Better Practice: Nursing Care Plans." RN, 1984 May: 103-104.

Wolff, LuVerne, Weitzel, M., et al. Fundamentals of Nursing. Philadelphia: J. B. Lippincott, 1983.

"Gross Negligence and Incompetence Defined." The BRN Report, Spring 1987 5(1).

APPENDIX A

NURSING CARE PLAN

APPENDIX B

SKILLS LABORATORY

Long Beach Community Colleges District
LONG BEACH CITY COLLEGE
Division of Nursing and Health Technologies

SKILLS LABORATORY
Writing Nursing Care Plans

Course Description

Designed to develop skill in the planning and implementation of nursing care of the hospitalized adult patient and the newborn. Activities include assessing physical and psychological needs, making nursing diagnoses, and planning nursing care.

Time Allotment

Practice Lab: 2 hours per week TBA

Texts

1. Brunner and Suddarth, Medical Surgical Nursing, 5th edition
2. Carpenito, Handbook of Nursing Diagnosis
3. Potter and Perry, Fundamentals of Nursing

How This Skill Will Be Learned

1. Read the above required texts as assigned.
2. Complete the assigned learning activities.
3. Review all classroom content as necessary

Teacher Responsibilities

1. Make daily assignments for specific learning activities.
2. Be available for questions in laboratory.
3. Give verbal feedback in regards to performance.

Student Responsibilities

1. Prior to the lab, review all care plan materials as necessary.
2. Independently practice writing care plans asking for help as needed.
3. Attend the practice laboratory regularly.

Learning Activities For Homeostasis

Write a nursing care plan for the patient that manifests symptoms of oxygen deprivation and immobility disorders.

Learning Activities For Major Health Problems

Write a nursing care plan for the patient that manifests symptoms of the following:

Gastrointestinal Disorders
- Hiatal Hernia
- Gastritis
- Hemorrhage
- Peptic Ulcer

Inflammatory Bowel Disease

Cardiac Problems
- Coronary Artery Disease
- Congestive Heart Failure

Metabolic Disorders
- Diabetes

Onocologic Conditions

Fluid and Electrolyte Imbalance

Preoperative and Postoperative Care

Learning Activities For Developmental Levels

Write a nursing care plan for the patient that manifests symptoms of the following:

Chronic Conditions
- Cerebralvascular Accident
- Head Trauma
- Chronic Obstructive Pulmonary Disease
- Hip Trauma/Fractures

Prototypes
- Newborn
- Postpartum Mother
  - 1 hour postpartum
  - 48 hours postpartum
  - C-Section (postop)